Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor Name and Address: NORTHWEST TEXAS HOSPITAL 3255 W PIONEERR PKWY ARLINGTON TX 76013	MFDR Tracking #: M4-11-1292-01 DWC Claim #: Injured Employee:
Respondent Name and Box #: INDEMNITY INSURANCE CO OF NORT Box #: 15	Date of Injury: Employer Name: Insurance Carrier #:

PART II: REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Understanding that TWCC is wanting to move to a hospital reimbursement of a %-over-Medicare, we have used that methodology in our calculation of fair and reasonable. Medicare would have reimbursed the provider at the base APC rate of $2870.07 for APC # 0131. Allowing this at 200% would yield a fair and reasonable allowance of $5,740.14. Also, Medicare would have reimbursed the provider at the base APC rate of $1173.73 for APC # 0130. Allowing this at 200% would yield a fair and reasonable allowance of $2347.46, but per the multiply [sic] procedure rule the correct allowable would be at 50%, making the correct allowable $1173.73. For all of the APC allowable the amount due totaled is $6913.87. Based on their payment of $6,119.20 for the APC a supplemental payment is still due of $794.67 on the APC alone, at this time."

Amount in Dispute: $794.67

PART III: RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Per the Requestor's Table of Disputed Services, they are disputing the payment of two separate CPT codes: 49650 and 49659. They billed $6,790.40 for CPT code 49650 which is more that [sic] the amount Requestor listed as the fee guideline amount. CPT code 49659 was paid at the $1.00 amount billed. No additional reimbursement should be owed. Requestor should not be allowed to bill such a small amount (i.e. $.00) and be reimbursed 1,000% more as they indicated the fee guideline amount was $1,173.73"

PART IV: SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Calculations	Amount in Dispute	Amount Due
12/21/09 – 12/22/09	CPT Codes 49650 and 49659	Total MAR for code 49650 is $5,740.14 and for code 49659 is $1,173.73 (50% for multiple procedure) ($6,119.20 – IC payment)	$794.67	$794.67
			Total Due:	$794.67

PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION

Texas Labor Code Section 413.011(a-d), titled *Reimbursement Policies and Guidelines*, and Division rule at 28 Texas Administrative Code §134.403, titled *Hospital Facility Fee Guideline – Outpatient*, effective for medical services provided in an outpatient acute care hospital on or after March 1, 2008, set out the reimbursement guidelines for hospital outpatient services.

This request for medical fee dispute resolution was received by the Division on December 17, 2010.

1. For the services involved in this dispute, the respondent reduced or denied payment with reason code:

- 802 – Charge for this procedure exceeds the OPPS schedule allowance.
- 45 – Charges exceed your contracted/legislated fee arrangement.
- W1 – Workers Compensation state fee schedule adjustment.
- 247 – A payment or denial has already been recommended for this service.
- 18 – Duplicate claim/service.
- 193 – Original payment decision is being maintained. This claim was processed properly the first time.
- W3 – Additional payment made on appeal/reconsideration.

2. Division rule at 28 TAC §134.403(e) states, in pertinent part, that "Regardless of billed amount, reimbursement shall be:
   (1) the amount for the service that is included in a specific fee schedule set in a contract that complies with the requirements of Labor Code 413.011; or
   (2) if no contracted fee schedule exists that complies with Labor Code 413.011, the maximum allowable reimbursement (MAR) amount under subsection (f), including any applicable outlier payment amounts and reimbursement for implantables;"

3. Pursuant to Division rule at 28 TAC §134.403(f), "The reimbursement calculation used for establishing the MAR shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors as published annually in the *Federal Register.* The following minimal modifications shall be applied.
   (1) The sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by:
      (A) 200 percent; unless
      (B) a facility or surgical implant provider requests separate reimbursement in accordance with subsection (g) of this section, in which case the facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 130 percent."

4. Under the Medicare Outpatient Prospective Payment System (OPPS), all services are classified into groups called Ambulatory Payment Classifications (APCs). Services in each APC are clinically similar and require similar resources. A payment rate is established for each APC. Depending on the services provided, hospitals may be paid for more than one APC per encounter. Within each APC, payment for ancillary and supportive items and services is packaged into payment for the primary independent service. Packaged services are considered integral to the primary paid service and are not separately reimbursed. An OPPS payment status indicator is assigned to each HCPCS code. The status indicator for each HCPCS code is shown in OPPS Addendum B, and a full list of status indicators and their definitions is published in Addendum D1 of the OPPS proposed and final rules each year, both of which are publicly available from the Centers for Medicare and Medicaid services.

5. Upon review of the documentation submitted by the Requestor and Respondent, the Division finds that:
   (1) No documentation was found to support a contractual agreement between the parties to this dispute;
   (2) MAR can be established for these services; and
   (3) Separate reimbursement for implantables was NOT requested by the requestor.

6. The Respondent states in their position summary that the Requestor should not be allowed to bill such a small amount and be reimbursed more as they indicated the fee guideline amount; however, Division rule at 28 TAC §134.403(e) states that regardless of the billed amount, reimbursement shall be the amount for the service that is included in a specific fee schedule set in a contract that complies with the requirements of Labor Code 413.011; or if no contracted fee schedule exists the maximum allowable reimbursed (MAR) amount under subsection (f), including any applicable outlier payment amounts and reimbursement for implantables.

7. Although CPT Code 49650, payable at $5,740.14, was not in dispute it was used in the calculations. CPT Code 49659 was disputed as not being paid at the correct APC rate plus the DWC multiplier of 200% minus 50% for multiple procedures.

Based upon the documentation submitted by the parties and in accordance with Texas Labor Code §413.031(c), the Division concludes that the requestor is due additional payment. As a result, the amount ordered is $794.67.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code §413.011(a-d), §413.031 and §413.0311
28 Texas Administrative Code §133.305, §133.307, §134.403
Texas Government Code, Chapter 2001, Subchapter G

PART VII: DIVISION DECISION

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $794.67plus accrued interest per Division rule at 28 TAC §134.130 and §413.019 (if applicable), due within 30 days of receipt of this order.

DECISION/ORDER:

Authorized Signature	Medical Fee Dispute Resolution Officer	Date

PART VIII: YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division rule at 28 TAC §148.3(c).

Under Texas Labor Code §413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 Rules if the total amount sought does not exceed $2,000. If the total amount sought exceeds $2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code §413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.